

**Instructions for completing ""Application for Maine Medical License Conversion to Volunteer Status" Form  
(for both Initial Applications and Renewal Applications)**

**Eligibility**

The following definition, which is taken from Board Rule Chapter 1, is intended to help you understand whether or not to complete the application to convert your Maine medical license to volunteer status.

**Volunteer Status** – The physician has retired or is retiring from the active practice of medicine and wishes to donate his or her expertise for the medical care and treatment of indigent and needy patients in the clinic setting of clinics organized, in whole or in part, for the delivery of health care services without charge.

If you have not retired from the practice of medicine and do not intend to only provide free medical care, do not apply for this license conversion.

**Requirements for Conversion**

1. Currently hold either an Active or Inactive status license in Maine.
2. If Inactive status, you must meet all the requirements of an active status license, including CME requirements as specified in Board Rule Chapter 1.
3. You have no license currently subject to discipline in any jurisdiction.
4. Your medical practice will be exclusively and totally devoted to providing medical care to needy and indigent persons in Maine. The treatment of family, acquaintances, or friends, is not authorized under this status.
5. You will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any medical services rendered under the Volunteer status license.

**Application Instructions**

1. Please type or print clearly in ink.
2. Answer all questions completely and clearly.
3. Submit the completed application together with all supporting documents and the NON-REFUNDABLE fee of \$75.00 to the Board of Licensure in Medicine.

**Liability Insurance data:**

This section must be completed if applying for registration in ACTIVE classification. Information you supply here is required for the Maine Rural Health Access Program (24-A MRSA, Ch. 75, §6304, (3)). The information will be reported to the Maine Superintendent of Insurance for administration of this program as provided in that law. Maintenance of professional liability insurance is not a requirement to maintain a Maine medical license in force. Please select 'Self Insurance' if you have no professional liability insurance, or if you only pay a portion of the premium.

**Background Data:**

Item **13** asks you to list any permanent medical practice license granted you by any state or Canadian province, whether or not it is still in force. Please do not list training permits or temporary or locum tenens licenses which you have been issued. If you were ever denied a license, see item **14 question 1**.

Item **14 questions 1-3** refer to events which may have occurred at any time since you completed your medical education and commenced your medical career.

Items **14 questions 4-22** ask you to disclose events which have occurred since your last renewal. You need not report again matters which were disclosed on previous applications unless you feel it would be helpful to our understanding of your current qualifications for medical practice. For example, you need not report a malpractice claim which arose and was settled prior to your last renewal. On the other hand, a claim filed in previous renewal periods which was closed by a settlement during your last renewal should be disclosed. If this is your first renewal, please disclose all data.

For any **"YES"** response, please provide a supplemental explanation in sufficient detail for the Board to understand the nature and seriousness of the problem and how it had been or is being resolved. For example: Item **14 question 9b** asks for disclosure with explanation of physical, psychiatric or addictive disorder which might reasonably be considered impairing for safe and unlimited medical practice unless the Board can confirm that you are either fully recovered or have taken adequate measures to compensate for any residual limitations. For physical or psychiatric problems, please give diagnosis, prognosis and residuals, any current limitations on scope of practice, and name and address of your treating physician who can confirm current fitness to continue practice. The Board will inform you if clinical records or reports are required. If you reported an impairing addictive disease on your registration application for a prior registration period, please so indicate and limit your response to methods and progress in recovery since your last renewal. Physicians residing in Maine, whether or not they are current members of the Maine Medical

Association, may obtain a confidential consultation with the Maine Medical Association's Medical Professionals Health Committee by calling (207)623-9266.

Item **14 question 19-20** regarding professional liability claims experience, are the questions most likely to generate follow-up letters from the Board staff and delay in your license renewal if not answered completely. Please report all claims of which you have been noticed since your last renewal. As well, report all claims since your last renewal from which you were dismissed as a defendant or for which your insurance company made a settlement of any kind with the plaintiff, or any claim for which a court found you liable in any degree. Claims against a professional corporation are considered a claim against the individual who provided the professional services in dispute.

To be complete, your supplemental explanation must include, for each such claim reported, a full description using the Professional (Malpractice) Liability Claim Experience Form attached. See the following fictitious example:

My Name: John B. Doe, MD

Identity of Case: Burns v. John B. Doe, MD, Samuel W. Smith, MD, Topeka Women's Hospital, Inc. et al.; Kansas Third Circuit Court, Topeka, Case #89-10203

Date/Place of Original Occurrence: June 4, 1990, Topeka Women's Hospital

Malpractice alleged by Claimant: Delayed diagnosis of ectopic pregnancy.

Summary of my Defense: I was a PGY II resident at the time. Dr. Samuel E. Smith, Chief of Obstetrics, Topeka Women's Hospital was attending physician in the case. I was named in the claim because my name appeared in the chart as the physician ordering ultrasound on first hospital day.

Current Status of the Case: Although a motion to dismiss me as a defendant is still pending, my insurance company has offered a settlement on my behalf of \$15,000 on February 14, 1992. I have been told that the plaintiff rejected this and the claim is still pending.

Name and address of Insurance Company/Attorney Defending Case: Great Plains Physicians' Mutual Indemnity, Attn: Jim Brown, Claims Manager, 4321 Ketcham Blvd. Rock Springs, SD 79104. I am also represented by William B. Eagle, Eagle-Hare P.A., 44 West River Drive, Suite 200, Topeka, KS 60301.

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#### Please Note:

### Mandated Reporter Requirements for Suspected Child Abuse

Maine law requires that physicians immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the physician knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. **In addition, Maine law requires physicians to immediately report to the Maine DHHS if a child is under 6 months of age or otherwise nonambulatory exhibits evidence of the following: Fracture of a bone; Substantial bruising or multiple bruising; Subdural hematoma; Burns; Poisoning; or Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ.**

**Mandated Reporter Training and additional information regarding mandated reporting can be found at:**

<http://www.maine.gov/dhhs/ocfs/cps/>

### Maine Prescription Monitoring Program

As of August 1, 2014, Maine law requires all Allopathic Physicians, Osteopathic Physicians, Dentists, Physician Assistants, Podiatrists, and Advanced Practice Registered Nurses who are licensed to prescribe scheduled medications to register with the Prescription Monitoring Program (PMP). To register, please go to the Prescription Monitoring Program website:

<http://www.maine.gov/pmp> Download, complete and sign a registration form located within the yellow box. You may mail, scan and email or fax a signed form to the information located on the form. Please note there are two types of registration forms available,

1) Data Requester form for active prescribers with a DEA number and, 2) Sub-Account form for assistants/non-prescribing health professionals.

More PMP information is available at: <http://www.maine.gov/dhhs/samhs/osa/data/pmp/prescriber.htm>

**The Board strongly recommends regular use of the PMP**

The Board's staff is available to assist you by phone at (207)287-3601, Monday through Friday, 8:00 am to 4:30 pm, Eastern Daylight time.

**M.D. Volunteer  
Conversion  
Application  
Fee: \$75.**

**Maine Board of Licensure in Medicine**

137 State House Station  
Augusta, ME 04333-0137  
(207)287-3601  
Fax: (207)287-6590

Fee: \_\_\_\_\_  
Exempt: \_\_\_\_\_  
Exp: \_\_\_\_\_  
Lpd: \_\_\_\_\_

**Application for Maine Medical License Conversion to Volunteer Status**

Fee: Please remit with application by check/money order payable to "Maine Board of Licensure in Medicine." **A fee is not currently required if you are age 70 or older.**

**Note: Any missing entry will render this application incomplete. Also failure to enclose the appropriate conversion fee, or report CME qualification will render your application incomplete.**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Country: \_\_\_\_\_

Daytime Phone No: \_\_\_\_\_ License No: \_\_\_\_\_  
Email address: \_\_\_\_\_

**Type of Licensure Status for Which You Are Applying:**

☐ 1. I am applying for conversion of my license to Volunteer status, based on evidence of CME qualification filed with this application.

**Personal Data Update:**

- A. If the spelling of your name, social security number, or date of birth preprinted above is not correct, please circle the error and legibly print the correct information.
- B. The Board requires BOTH your HOME mailing address and phone number, and the address and phone number of your PRINCIPAL PLACE OF MEDICAL PRACTICE. You may designate which of the two you wish to be used for mailings from the Board, but that default address is the home address, unless you specify otherwise (by selecting "P" for 'practice address'). Unless you specify otherwise, your practice address will be the address circulated by the Board in listings and publications available to the general public, including the Internet. If you currently have no practice address and you do not wish for your home address to be on the Internet, you must provide an alternate address, such as a Post Office box, or a mail drop.

5. I Prefer Board contact me at Home, or at Practice. (H/P) \_\_\_\_\_

**My Home mailing address and phone are:**

Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Country: \_\_\_\_\_  
Daytime Phone No: \_\_\_\_\_

**My Practice mailing address and phone are:**

Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Country: \_\_\_\_\_  
Daytime Phone No: \_\_\_\_\_

**PRACTICE DATA:** If your practice data is incorrect, please correct in the space provided.

7. At present I practice medicine (check all that apply):

- ☐ Full Time ☐ Hospital-based Practice ☐ Solo ☐ Do not see patients (i.e. Administrative, Research, Teaching, etc.)  
☐ Part Time ☐ In Partnership or Group ☐ Retired

**Check box if ABMS certified in each specialty.**

8. Primary Specialty: \_\_\_\_\_ ☐ 10. Sub-Specialty 2: \_\_\_\_\_ ☐

9. Sub-Specialty 1: \_\_\_\_\_ ☐

11. I am ABMS Specialty Board certified (Y/N) \_ by: (Board name) \_\_\_\_\_ ☐

**LIABILITY INSURANCE DATA:**

Although maintenance of professional liability insurance is not a requirement for Maine licensure, the Board is required to provide data about each licensee's source of insurance, if any, to the Superintendent of Insurance to aid in the administration of the Maine Rural Health Access Program pursuant to 24-A MRSA, Ch. 75, § 6304, (3).

12. Please indicate the method you employ to secure professional medical malpractice liability insurance.

If you have no coverage answer "Y" to 'Self Insured':

- Are you Self Insured (Y/N) \_\_\_\_
- Is your insurance Physician Paid (Y/N) \_\_\_\_
- Is your insurance Employer Paid (Y/N) \_\_\_\_

If you checked off "Employer Paid", please enter the name of the employer who or which paid your premiums here: \_\_\_\_\_

Insurance Company (Name/Address):

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

Daytime Phone No: \_\_\_\_\_

Policy #: \_\_\_\_\_

**BACKGROUND DATA:**

**(All Applicants must complete. Use additional sheet if necessary)**

13. Other than in Maine, I currently hold, or I have at one time held, a permanent license to practice medicine in the following states (or territories) of the United States or provinces of Canada (exclude temporary, Locum tenens, or permits/certificates allowing training in the capacity of clinical clerk, intern, resident, or fellow):

	State	Certificate #	Expiration Date	Present Status
1				
2				
3				
4				
5				

(Please make corrections to information below)

	State	Certificate #	Expiration Date	Present Status
1				
2				
3				
4				
5				

☐ I have never held a permanent medical practice license except in Maine.

14. Check off (X) each appropriate response. Every 'YES' response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and enclosed with your application.

**NOTE TO MD/APPLICANT: PLEASE COMPLETE THIS FORM YOURSELF – DO NOT DELEGATE ITS COMPLETION.**

**HAVE YOU EVER:**

**YES NO**

- ☐ ☐ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?
- ☐ ☐ 2. Have you EVER agreed with any licensing authority to voluntarily follow practice limitations, restrictions, guidelines, to make reports or to complete specific continuing education or course work?
- ☐ ☐ 3. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?

**SINCE YOUR LAST RENEWAL APPLICATION:**

**YES NO**

- ☐ ☐ 4. Have you left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?
5. Have you been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to
- ☐ ☐ a) U. S. Drug Enforcement Administration (DEA)?
- ☐ ☐ b) Any state/territory of U. S. INCLUDING MAINE?
- ☐ ☐ 6. Has there been a finding by any state or federal court or governmental agency that you violated any rule or law regulating the practice of health care?
- ☐ ☐ 7. Has there been a finding against you in any inquiry, investigation, or administrative or judicial proceeding by an employer, educational institution, professional organization, or licensing authority, or in connection with an employment disciplinary or termination procedure?
- ☐ ☐ 8. Have you received a sanction regarding Medicare or any state Medicaid program?
9. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.
- ☐ ☐ a. Do you have a mental or physical condition that currently impairs your ability to safely and competently practice medicine?
- ☐ ☐ b. Have you been diagnosed with or treated for any medical or mental health disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?
- ☐ ☐ c. Do you currently use any chemical substance(s), including alcohol, which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?
- ☐ ☐ If any of your answers to questions 8(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or substance misuse condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program? Current voluntary participation in the Medical Professionals Health Program or similar program will be kept confidential?
- ☐ ☐ N/A
- ☐ ☐ d. Are you currently engaged in the illegal use of illicit drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship? "Legitimate" means "Being in compliance with the law or in accordance with established and accepted standards."

- ☐ ☐ e. Have you used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?

**SINCE YOUR LAST RENEWAL APPLICATION:**

**YES NO**

- ☐ ☐ f. Have you used illegal drugs or prescription drugs that have not been prescribed to you pursuant to a legitimate physician-patient relationship?
- ☐ ☐ g. Have you furnished or provided illegal drugs to anyone other than medical marijuana per applicable state law?
- ☐ ☐ h. Have you furnished prescription drugs to or written a prescription for anyone without having a legitimate physician-patient relationship (This includes conduct for which you may NOT have been adjudicated in any civil, administrative or criminal proceeding)?
- ☐ ☐ i. Have you been found in any civil, administrative or criminal proceeding to have:
- ☐ ☐ a. Possessed, used, prescribed for use, or distributed any drugs in any way other than for legitimate or therapeutic purposes?
- ☐ ☐ b. Diverted any drugs?
- ☐ ☐ c. Violated any drug law?
- ☐ ☐ d. Prescribed any controlled substances for yourself or family/household members?
- ☐ ☐ j. Have you raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or substance misuse disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?
- ☐ ☐ 10. Have you been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses such as Operating Under the Influence, but not minor traffic or parking violations.
- ☐ ☐ 11. Have you applied for hospital, HMO or other health care entity privileges which were denied?
- ☐ ☐ 12. Have you had your staff privileges or employment at any hospital, long term care facility, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?
- ☐ ☐ 13. Have you voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?
- ☐ ☐ 14. Have you resigned from employment in lieu of termination or while under investigation?
- ☐ ☐ 15. Have you been terminated or suspended from any employment?
- ☐ ☐ 16. Have you been deselected from a managed care organization physician panel?
- ☐ ☐ 17. Have you been disciplined by a professional society or resigned while an accusation was pending?
- ☐ ☐ 18. Have you endangered the safety of others, breached fiduciary obligations, or violated workplace conduct rules?
- ☐ ☐ 19. Have you been named in any medical malpractice liability claim or lawsuit, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent?
- ☐ ☐ 20. Do you have any open/pending malpractice claims?
- ☐ ☐ 21. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?
- ☐ ☐ 22. Do you plan to practice telemedicine in Maine:
- ☐ ☐ a. From within the state?
- ☐ ☐ b. From within the state?
- ☐ ☐ c. Will you combine face to face practice and telemedicine?
- ☐ ☐ d. Will you practice only in conjunction with a state licensed physician?

**AFFIDAVIT OF APPLICANT:**

(All applicants must personally sign and date whether applying for "active" or "inactive" renewal of license or requesting withdrawal of licensure status.)

I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the state of Maine, or other discipline as the Board may determine. I acknowledge my responsibility to notify the Maine Board of Licensure in Medicine of my subsequent change in my status from that reported here and, in particular, to notify the Board within 10 days of a change in my place of medical practice or residence.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_, MD

Typed or Printed Name: \_\_\_\_\_, MD

For Office Use Only:

Staff Rev Date: \_\_\_\_\_ Recommendation: \_\_\_\_\_

**Voluntary Practice Information:**

15. "Volunteer Status – The physician has retired or is retiring from the active practice of medicine and wishes to donate his or her expertise for the medical care and treatment of indigent and needy patients in the clinic setting of clinics organized, in whole or in part, for the delivery of health care services without charge."

As part of the application the physician will report all locations where the physician will be providing volunteer services.

	Clinic Name	Address	Phone
1			
2			
3			
4			
5			

Note: The physician will have a written agreement to provide volunteer services at every facility where services will be provided.



## **CONTINUING MEDICAL EDUCATION REPORT**

For reporting CME credits earned during the previous 24 months.

100 credit hours are required to convert your license to volunteer status, at least 40 of which must be Category I

The Board will routinely and regularly audit CME credits claimed. Failure to provide proof of CME credits claimed upon request by the Board may be grounds for discipline.

**Therefore, it is vitally important that you retain documentation of all CME claimed.**

### **Category I**

Category I includes programs that have received accreditation by the AMA Council on Medical Education, the Accreditation Council for Continuing Medical education (ACCME), or the Committee on CME of the Maine Medical Association. [Refer to Chapter 1, §13 of the Rules of the Maine Board of Licensure in Medicine for specific definitions. See <http://www.maine.gov/sos/cec/rules/02/373/373c001.doc> ] Forty (40) CME credits must be in Category I. Category I CME's earned outside the U.S. or Canada must be approved by the Board; therefore such activities must be separately documented.

Total Category I Credits Earned\_\_\_\_\_

### **CATEGORY II**

Category II includes programs with non-accredited sponsorship, i.e., Medical Teaching, Papers, Books, Publications, and Exhibits. Also included are non-supervised individual CME activities and other Meritorious learning Experiences. [Refer to Chapter 1, §13 of the Rules of the Maine Board of Licensure in Medicine for specific definitions. See <http://www.maine.gov/sos/cec/rules/02/373/373c001.doc> ] Sixty (60) CME credits are required.

NOTE: Category I may be substituted for Category II.

Total Category II Credits Earned\_\_\_\_\_

**AFFIDAVIT: I CERTIFY THAT THIS IS A TRUE AND CORRECT REPORT OF MY CME ACTIVITY.**

Date: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Typed or Printed Name: \_\_\_\_\_, MD

# Maine Board of Licensure in Medicine Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims.

My Name: \_\_\_\_\_

Identity of Case: \_\_\_\_\_

Date and Place of Original Occurrence: \_\_\_\_\_

\_\_\_\_\_

Malpractice Alleged By Claimant: \_\_\_\_\_

\_\_\_\_\_

Summary of My Defense: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Status of Case (Include payment amount): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name and Address of Insurance Company and/or Attorney Defending the Case: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_